(The remarks of Mr. CARDIN pertaining to the introduction of S. 657 are located in today's RECORD under ''Statements on Introduced Bills and Joint Resolutions.'')

Mr. CARDIN. I yield the floor and suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. KYL. I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

OBAMACARE

Mr. KYL. Mr. President, last Wednesday marked the 1-year anniversary of the deeply flawed health care bill. The worst aspect of that bill is that it will lead to health care rationing by the Federal Government. That is the delay and denial of care in order to control costs. The words ''ration,'' ''withhold coverage'' and ''delay access to care'' of course are not found anywhere in the bill. But new Federal rules that aim to reduce health care costs will inevitably result in delayed or denied tests, treatments, and procedures deemed too expensive and in less innovation in the development of drugs, devices, and treatments. Many of the decisions will be based on information provided by a new entity called the Patient-Centered Outcomes Research Institute, sometimes referred to as the PCORI. That will conduct comparative effectiveness research.

Comparative effectiveness research weighs the effectiveness of two or more health care services or treatments. The goal is to provide patients and doctors with better information regarding the risks and benefits of, for example, a drug versus a surgery for a particular situation. The problem is not with the merits of the research but whether the research should be used by the government to determine treatments and services covered by one's insurance. The health care law actually empowers the Secretary of Health and Human Services to do just that, to use this comparative effectiveness research when making coverage determinations.

Section 6301 of ObamaCare states:

> The Secretary may [. . .] use evidence and findings from research conducted [. . .] by the Patient-Centered Outcomes Research Institute.

That means the government, not patients and doctors, has the power to make health care decisions that affect you. A bureaucrat decides if your health care is an effective use of government resources without regard to the patient's individual needs and medical history. The end result is the government inevitably interferes with access to care. That is rationing, and it is wrong.

While ObamaCare includes limited safeguards for how this research may be used—appreciating the dangers involved—there is nothing that prohibits the government from taking it into account when, for example, making Medicare coverage decisions.

In fact, when asked whether the Federal CER agency should be involved in cost determinations, Donald Berwick, the President's recess-appointed head of the Centers for Medicare and Medicaid, responded:

> The social budget is limited.

Ask citizens in Britain how well the system is working in their country. Britain's National Institute for Health and Clinical Excellence—called NICE—routinely uses comparative effectiveness research to make cost-benefit calculations.

Last year, NICE rejected a cutting-edge drug, Avastin, used to treat bowel cancer because it said the drug's limited effectiveness for extending life—they said 6 weeks; but up to 5 months according to the chief executive of the organization, Beating Bowel Cancer—they said it did not justify the cost. As Mike Hobday, head of policy at the charity, Macmillan Cancer Support, told Britain's Daily Telegraph:

> We think this is devastating news for cancer patients with metastic colorectal cancer, especially as this drug could have a significant impact on peoples' quality of life. Although a few extra weeks or months might not sound much to some people it can mean an awful lot to a family affected by cancer.

Likewise, in August 2008, NICE recommended against coverage of four expensive drugs for advanced kidney cancer. NICE considered the drugs clinically beneficial in specific situations but concluded they ''were not cost-effective within their licensed indications.''

Health care in Britain is also routinely delayed. Several years ago, the country's National Health Service launched an ''End Waiting, Change Lives'' campaign—''End Waiting, Change Lives.'' The campaign's goal was to reduce a patient's wait time to 18 weeks from referral to treatment. That is 4½ months, and that is an improvement.

Government-run health care systems that ration care are the reason many Europeans and Canadians come to the United States each year to get treatments denied to them in their own countries.

Access to the highest quality care and the sacred doctor-patient relationship are the cornerstones of U.S. health care—the very things Americans value most and that the health care law jeopardizes.

So I will join Senators COBURN, BARRASSO, ROBERTS, and CRAPO in introducing the Preserving Access to Targeted, Individualized, and Effective New Treatments and Services Act of 2011. That is also known as the PATIENTS Act.

The PATIENTS Act does not prohibit comparative effectiveness research; rather, it is a propatient firewall that protects patients' access to high-quality care by prohibiting the Federal Government from using comparative effectiveness research to delay or deny care.

Additionally, the bill would require comparative effectiveness research to account for differences in the treatment response and preferences of patients, genomics and personalized medicine and the unique needs of health disparity populations and it would clarify that nothing shall be construed as affecting the FDA Commissioner's authority to respond to drug safety concerns.

All Americans deserve personalized treatment and should be able to get the care they and their doctors decide is best for them. No Washington bureaucrat should interfere with that right by substituting the government's judgment for that of a physician.

The administration has repeatedly promised that the health care law will not result in rationing. Well, if that promise is true, they should have no problem supporting the PATIENTS Act.

I urge my colleagues to join us in cosponsoring this important legislation.

I suggest the absence of a quorum.

The ACTING PRESIDENT pro tempore. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Ms. LANDRIEU. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The ACTING PRESIDENT pro tempore. Without objection, it is so ordered.

CONCLUSION OF MORNING BUSINESS

The ACTING PRESIDENT pro tempore. Morning business is closed.

SBIR/STTR REAUTHORIZATION ACT OF 2011

The ACTING PRESIDENT pro tempore. Under the previous order, the Senate will resume consideration of S. 493, which the clerk will report.

The assistant legislative clerk read as follows:

> A bill (S. 493) to reauthorize and improve the SBIR and STTR programs, and for other purposes.
>
> Pending:
>
> McConnell amendment No. 183, to prohibit the Administrator of the Environmental Protection Agency from promulgating any regulation concerning, taking action relating to, or taking into consideration the emission of a greenhouse gas to address climate change.
>
> Vitter amendment No. 178, to require the Federal Government to sell off unused Federal real property.
>
> Inhofe (for Johanns) amendment No. 161, to amend the Internal Revenue Code of 1986 to repeal the expansion of information reporting requirements to payments made to corporations, payments for property and other gross proceeds, and rental property expense payments.
>
> Cornyn amendment No. 186, to establish a bipartisan commission for the purpose of improving oversight and eliminating wasteful government spending.